Nevada Department of Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Nevada Opioid Crisis Needs Assessment

June 2018

State Targeted Response to the Opioid Crisis Grant Program

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Purpose

The purpose of this needs assessment is to identify the opioid use disorder (OUD) crisis in Nevada related to:

- the geographical and demographic areas where opioid misuse and related harms are most prevalent;
- all existing activities and funding sources in the state/jurisdiction that address opioid use prevention, treatment and recovery activities; and
- gaps in the existing services and resources to be addressed.

The needs assessment will inform decision making on how to best address the opioid crisis.

Executive Summary

There is variation in the racial/ethnic backgrounds or counties with the highest prevalence of opioid-related indicators, depending on the measure considered. Racial/ethnic, county or regional-level data was obtained for 13 indicators. Several indicators did not have significant differences. Differences are outlined below.

Opioid painkiller prescribing rates have decreased since 2012, while benzodiazepine prescribing rates have remained steady. Nevada counties with the highest prescription rates for both opioid painkillers and benzodiazepines are Mineral, Nye, and Storey counties. Death rates are highest among whites and individuals between the ages of 45-64 and lowest among Asian/Pacific Islander and Hispanic/Latino individuals. Death trends differed by type of opioid. Heroin deaths increased from 2010-2015, then remained stable from 2015-2016. Synthetic opioid deaths (i.e. fentanyl) increased from 2015-2016. Methadone overdose deaths decreased from 2010-2016.

Prescription drug use decreased slightly from 2011-2015 among high school students. Use was lowest among Asian adolescents. Past month prescription drug use was lowest in Elko/White Pine/Eureka counties and Churchill/Humboldt/Pershing/Lander counties.

Naloxone administration increased in emergency departments (ED) from 2010-2016 but was only used for a small percentage of total opioid poisonings. Opiate-related hospital admissions have increased during this period as well for both ED visits and inpatient (IP) admissions. Opioid poisonings, a subset of opioid-related hospitalizations, remained stable from 2010-2016. The category of opioid-involved poisonings shifted, with opioid poisonings from heroin increasing in the ED and opioid poisonings from methadone and other opioid and narcotics decreasing in ED and IP admissions.

The current sociopolitical climate in Nevada is favorable to addressing the opioid crisis. Key legislation was passed in the 2015 and 2017 legislative sessions to combat the opioid crisis. Nevada is one of only two states to meet all six key actions for ending the opioid crisis (National Safety Council, 2018). Gov. Brian Sandoval has been instrumental in increasing awareness of the problem, bringing together state and national experts, and introducing legislation to address the crisis. Attorney General Adam Laxalt has played a key role in legislation and statewide prevention efforts.

Through multiple funding sources, EMTs, healthcare providers, mental health professionals, drug court professionals, and interested parties have received varying levels of training on overdose education and naloxone distribution. Naloxone is available without a prescription in CVS and Walgreens pharmacies and Smith's Food and Drug Stores, with coverage of naloxone available through Medicaid and certain commercial insurance companies. Naloxone is available free of charge through Trac-B Exchange in Las Vegas, Northern Nevada HOPES in Reno, community coalition events, and Integrated Opioid Treatment and Recovery Center outreach. Community coalitions have conducted presentations statewide to educate parents, youth, seniors, real estate agents, and veterans on prescription drug abuse. Media campaigns and drop box/take back events have taken place in the majority of communities. One recovery community organization exists in Las Vegas, offering a wide variety of services.

Some gaps exist in addressing the crisis. Opioid Treatment Programs (OTP) only exist in Clark County, Washoe County and Carson City. Office-Based Opioid Treatment (OBOT) providers are only available to prescribe to patients in 10 counties, none of which are prescribing at capacity. OBOTs cite no time for additional patients, insufficient reimbursement rates, and a lack of patients looking for Medication Assisted Treatment (MAT) as reasons for not prescribing MAT to more patients. Providers are looking for more information on counseling resources in their local areas to be able to give to patients.

Introduction

The opioid crisis is impacting the entire country. Since 1999, the amount of prescription opioids dispensed in the United States and the number of overdose deaths involving opioids have both quadrupled (CDC, 2017b). In 2016, Nevada ranked 13th in opioid painkiller prescribing rates, at 80.7 per 100 residents, compared to a national average of 66.5 (CDC, 2017a). Heroin seizures in Nevada more than doubled from 2014 to 2015 (Nevada HIDTA, 2016). Neonatal exposure to substances has increased each year since 2012 (Nevada Division of Child & Family Services, 2017).

The crisis is complex and multifaceted and will need a coordinated effort to address it. Nevada's vast geography and healthcare provider shortage contribute to the challenge of the addressing the problem. Ninety percent (90%) of Nevada's population is concentrated Clark County, Washoe County, and Carson City. The remaining 10% is dispersed throughout the remaining 14 rural and frontier counties, where the distance between major rural towns averages 100 miles. The number of licensed alcohol, drug, and gambling counselors has declined from 45.0 to 42.1 per 100,000 since 2008 (Griswold et al., 2017). On the other hand, the number of healthcare providers who are Data 2000 waivered to prescribe buprenorphine has increased from 98 in 2013 to 250 in 2018 (Levi, et al., 2013; SAMHSA, 2018). Even where there is access, stigma and lack of knowledge about services reduce the number of persons who enter opioid use disorder treatment.

The Substance Abuse and Mental Health Services Administration (SAMHSA) released two years of funding to combat the crisis through the Opioid State Targeted Response (STR) to the Opioid Crisis Grant. To determine how to focus programming, a needs assessment was completed, taking into account areas of highest use and consequences, resources and efforts already in existence, and gaps between need and resources. This needs assessment is considered a living document, and as such, will be updated as more information becomes available.

Data Sources

The secondary data contained in this report was drawn from the following sources:

- Nevada Division of Public and Behavioral Health Office of Public Health Informatics and Epidemiology (OPHIE),
- Nevada Prescription Monitoring Program (PMP),
- Nevada Electronic Death Registry System,
- Center for Health Information Analysis for Nevada,
- Hospital Inpatient and Emergency Department Billing Data,
- Centers for Disease Control and Prevention (CDC) Wonder,
- Youth Risk Behavior Surveillance (YRBS),
- Behavior Risk Factor Surveillance System (BRFSS),
- National Emergency Medical Services Information System (NEMSIS),
- data reported from Nevada Opioid Treatment Providers,
- and coalition behavioral health reports.

Additional data collection was conducted through an online survey. A request to complete the survey was sent to all Data 2000 waivered physicians through the Chief Medical Officer and the Board of Pharmacy with follow-up reminders.

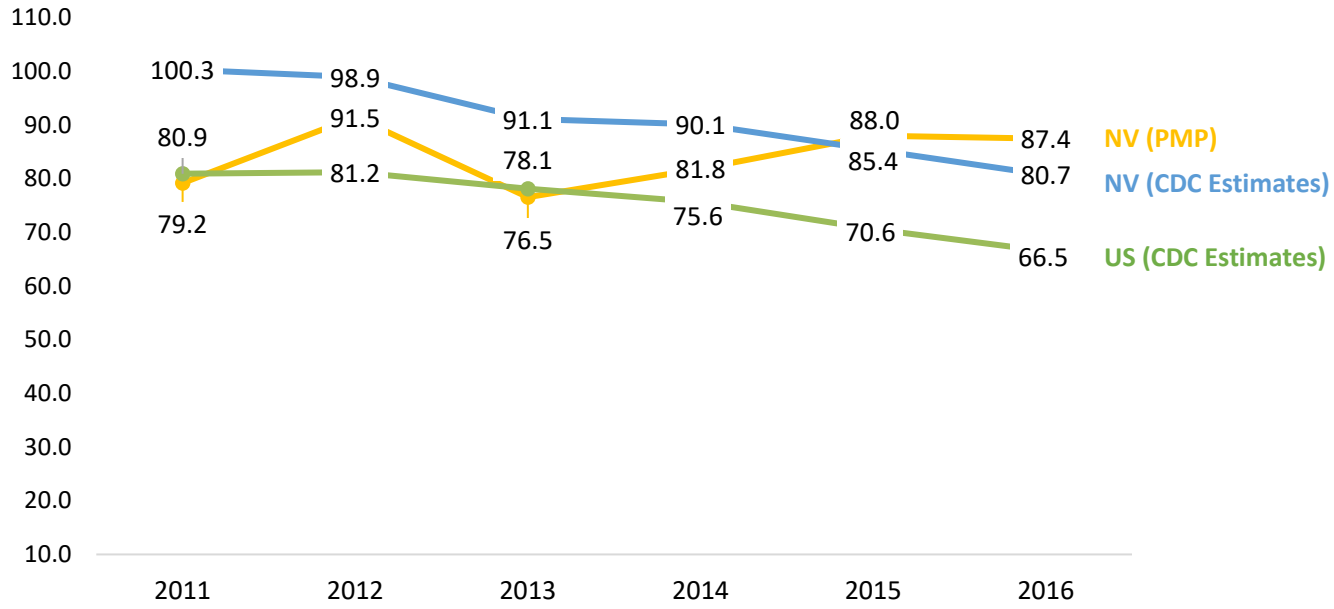
Please see page 35 for definitions of terms of relevance to the document.

Prescribing Rates

The most recent annual data on opioid painkiller and Benzodiazepine prescribing rates available from Nevada's PMP and the CDC are summarized below.

Based on data from the Nevada PMP, the opioid painkiller prescribing rate has decreased since its highest point in 2012. CDC estimates show opioid prescribing rates in Nevada continuing to decline. The two sources use different definitions of opioids and population. The CDC rates are estimates based on a sample of pharmacies.

Figure 1. Opioid Painkiller Prescriptions per 100, 2011-2016



*Definitions vary slightly between CDC and PMP opioid prescriptions and populations used to calculate rates
(Sources: Guy et al., 2017; Office of Public Health Informatics and Epidemiology; Prescription Monitoring Program)

Opioid prescribing rates are highest in Mineral County (158.1), followed by Nye County (155.6), Storey County (146.9), and Lyon County (129.9). Nine (9) counties have prescribing rates higher than the state prescribing rate (87.4) and 14 counties are higher than the U.S. prescribing rate (66.5). Esmeralda County and Pershing County saw a decrease in opioid prescribing rates of 18% and 17%, respectively, from 2015 to 2016. The counties with the largest increase in percent change in prescribing rates from 2015 to 2016 are: Lincoln (40%), White Pine (22%), Mineral (17%) and Eureka (14%) counties. See Table 1 for prescribing rates for each county. All prescriptions are reported by county where the patients live. This may be different than the county where the prescription was written.

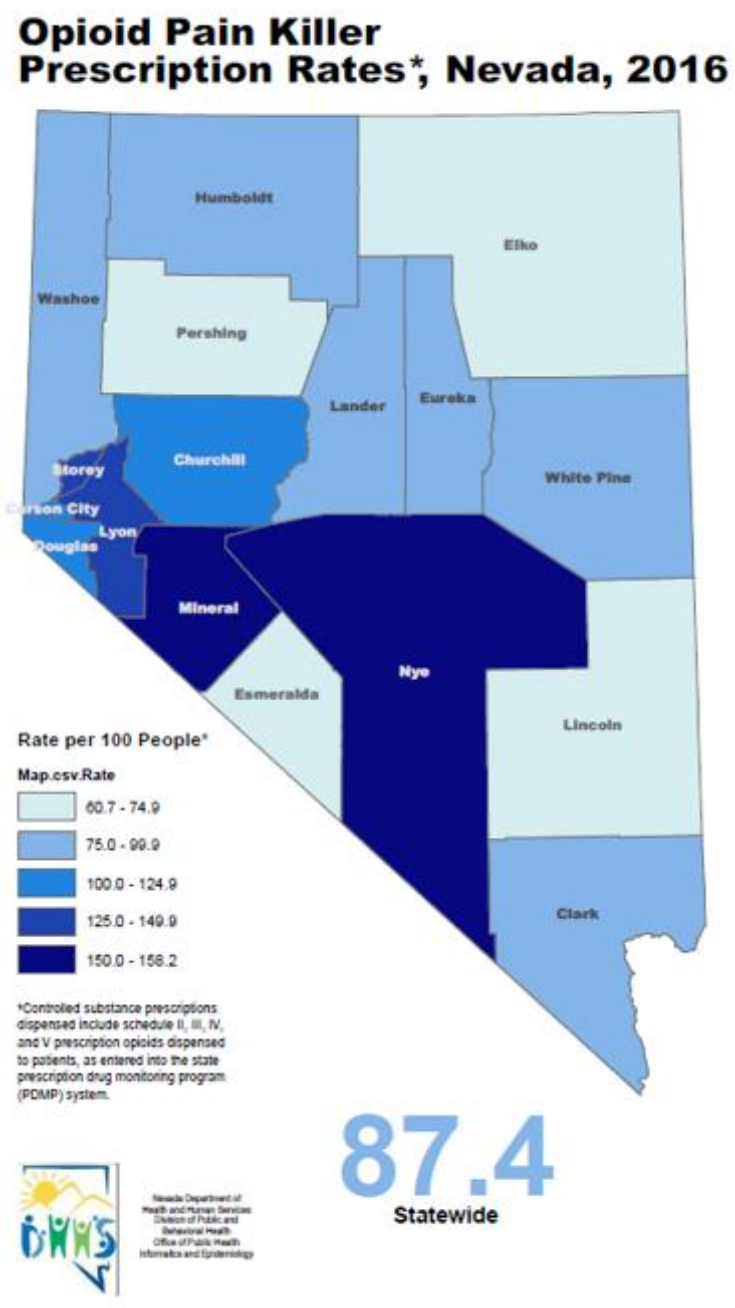


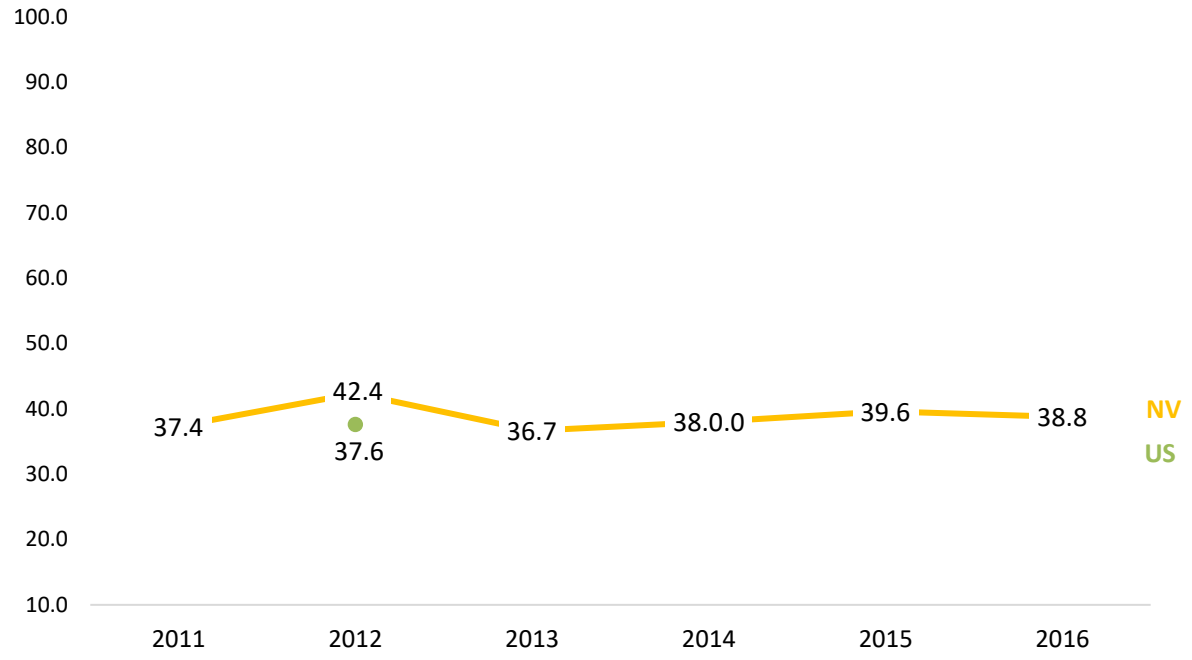
Table 1. Opioid Painkiller Prescribing Rates Per 100, by County, 2016

County	Rate
Carson City	105.3 (104.4-106.2)
Churchill	106.8 (105.5-108.0)
Clark	84.2 (84.0-84.3)
Douglas	102.0 (101.1-102.9)
Elko	71.6 (70.9-72.4)
Esmeralda	72.4 (67.1-77.7)
Eureka	92.7 (88.4-97.0)
Humboldt	75.5 (74.2-76.8)
Lander	85.2 (83.0-87.5)
Lincoln	60.7 (58.5-62.8)
Lyon	129.9 (129.0-130.9)
Mineral	158.1 (154.5-161.8)
Nye	155.6 (154.4-156.7)
Pershing	69.4 (67.4-71.3)
Storey	146.9 (143.2-150.6)
Washoe	87.4 (87.1-87.7)
White Pine	99.9 (97.9-101.8)
Nevada	87.4 (87.3-87.6)

(Sources: Office of Public Health Informatics and Epidemiology; PDMP)

Nevada's Benzodiazepine prescribing rate remained stable from 2013 to 2017.

Figure 2. Benzodiazepine Prescriptions Per 100, 2011-2016



(Sources: Paulozzi, et al., 2014; Office of Public Health Informatics and Epidemiology; Prescription Monitoring Program)

The Benzodiazepine prescribing rate is highest in Nye County (65.6), Storey County (60.7), and Mineral County (55.9)—each significantly higher than the state prescribing rate of 38.8. The Benzodiazepine prescribing rate in Pershing County decreased by 20% from 2015 to 2016. Conversely, the prescribing rates percent change increased by 46% in Lincoln County, 21% in Mineral County, and 14% in White Pine County from 2015 to 2016.

The top three opioid prescribing counties—Mineral, Nye, and Storey Counties—are the same counties as the top three Benzodiazepine prescribing counties, indicating these counties are at highest risk for overprescribing.

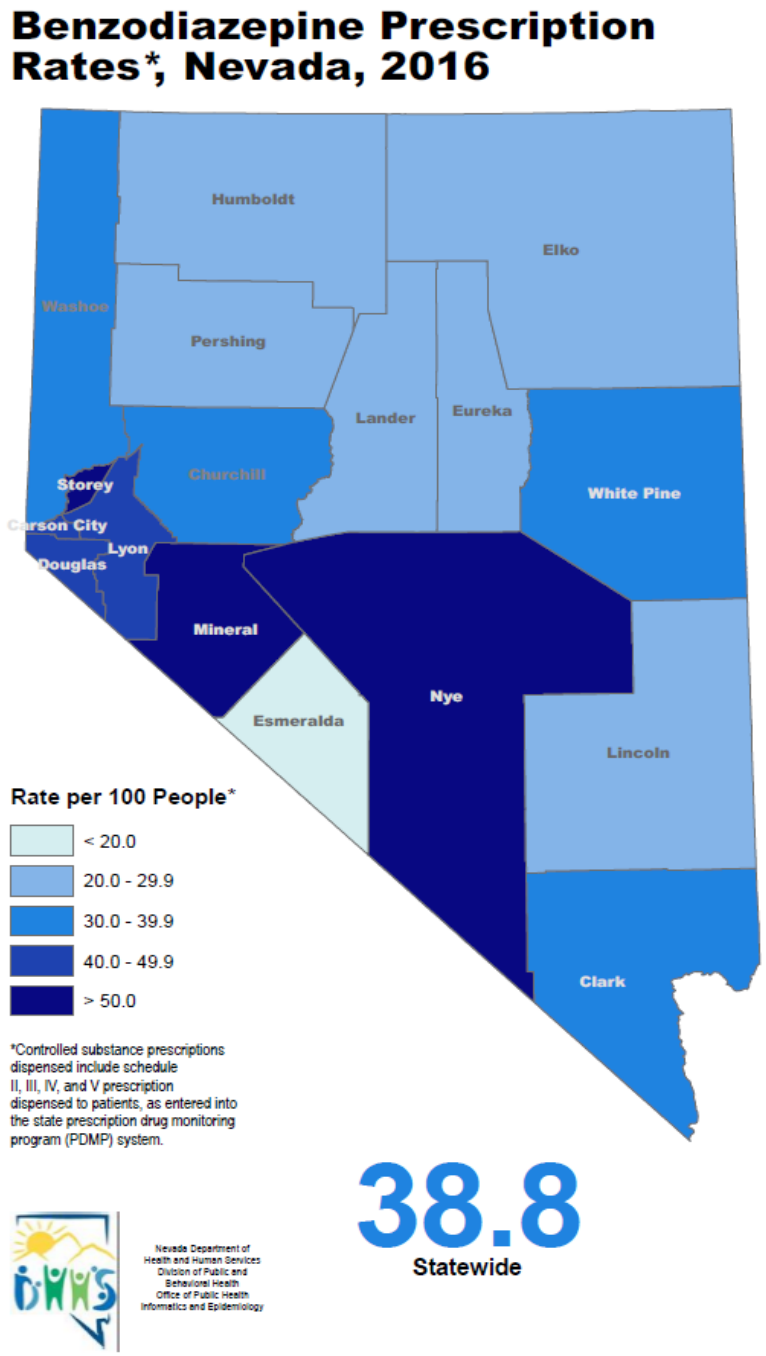


Table 2. Benzodiazepine Prescription Rates Per 100 by County, 2016

County	Rate
Carson City	47.9 (47.3-48.5)
Churchill	38.9 (38.1-39.6)
Clark	38.2 (38.1-38.3)
Douglas	45.5 (44.9-46.1)
Elko	26.1 (25.7-26.5)
Esmeralda	18.9 (16.1-21.6)
Eureka	29.3 (26.9-31.7)
Humboldt	26.6 (25.8-27.4)
Lander	26.8 (25.6-28.1)
Lincoln	26.2 (24.8-27.6)
Lyon	45.5 (44.9-46.0)
Mineral	55.9 (53.7-58.0)
Nye	65.6 (64.8-66.3)
Pershing	20.9 (19.8-22.0)
Storey	60.7 (58.3-63.1)
Washoe	38.5 (38.4-38.7)
White Pine	33.4 (32.3-34.6)
Nevada	38.8 (38.7-38.9)

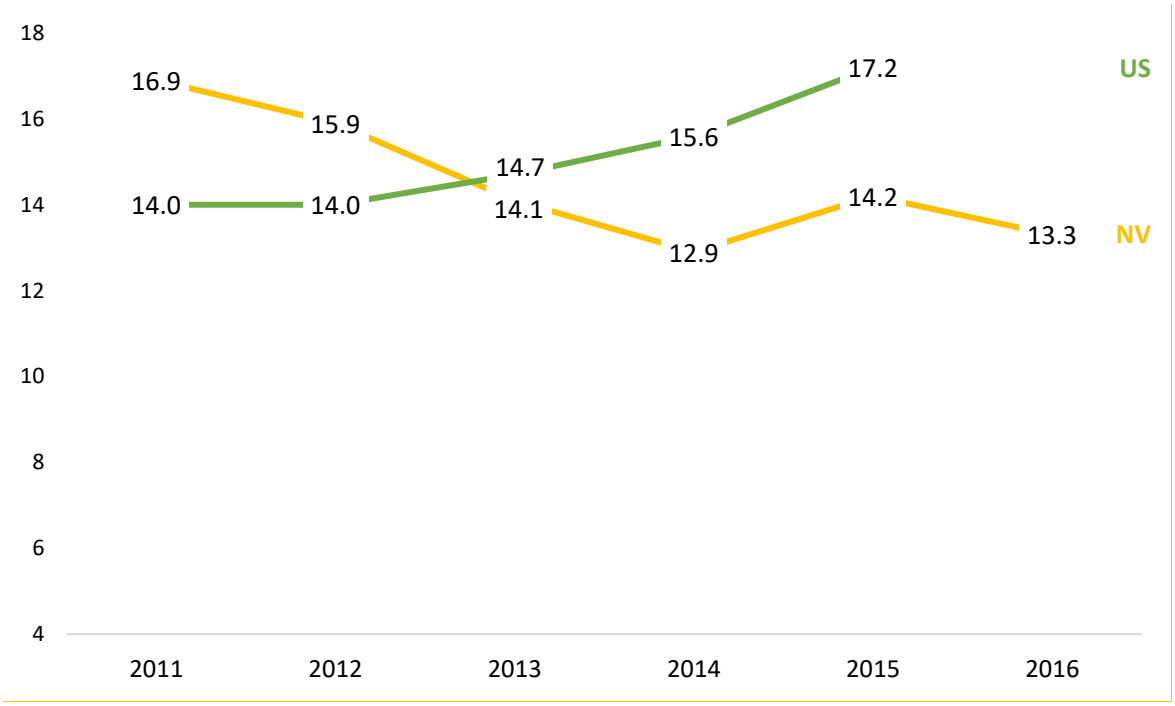
(Sources: Office of Public Health Informatics and Epidemiology; PDMP)

Opioid-Involved Overdose Deaths

The most recent annual data available for Nevada's opioid-involved overdose deaths are summarized below.

The opioid-related overdose rate in Nevada has been lower than the U.S. rate for the past four years. There has been a 22% decrease in overdose-related deaths since 2011 and a 6% decrease in overdose-related deaths since 2015.

Figure 3. Opioid-Related Deaths per 100,000, 2011-2016



*Data are preliminary and subject to change.
**Includes ICD-10 codes as underlying cause of death: X40-X44, X60-X64, X85, Y10-Y14, as contributing cause of death: T40.0-T40.4, T40.6
(Sources: CDC Wonder; Office of Public Health Informatics and Epidemiology; Electronic Death Registry System)

The table below shows age-adjusted opioid overdose death rates by county in 2016. Rates are age-adjusted so that they can be compared across regions and with other states and national statistics.

Table 3. Opioid Overdose Death Rates Per 100,000 by County, 2016

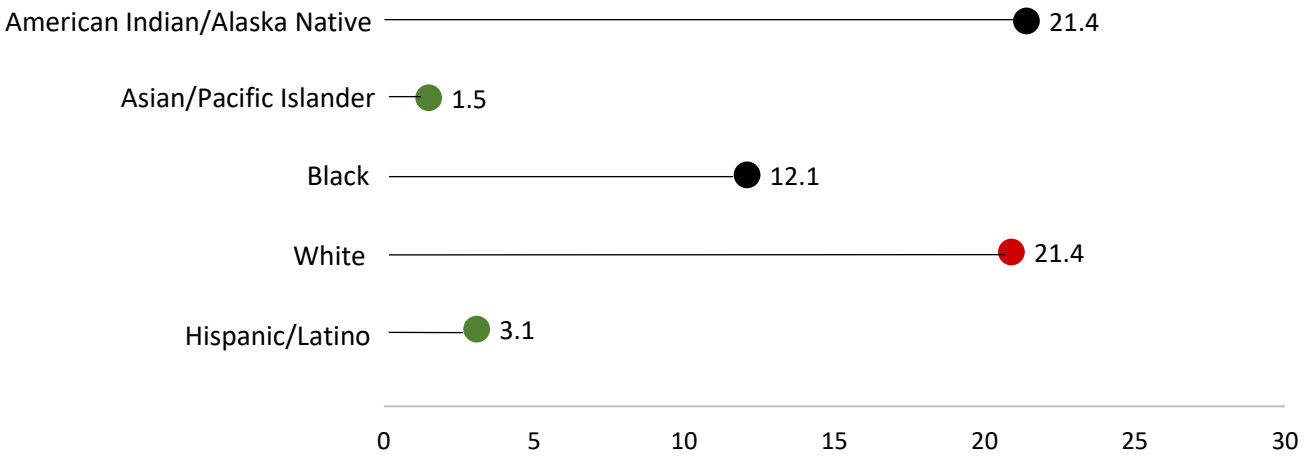
County	Number	Age-Adjusted Rate
Carson City	8	14.3 (4.4-24.2)
Churchill	3	9.4 (0.0-19.9)
Clark	271	12.3 (10.8-13.7)
Douglas	7	13.4 (3.5-23.2)

County	Number	Age-Adjusted Rate
Elko	1	1.8 (0.0-5.4)
Esmeralda	0	-
Eureka	0	-
Humboldt	2	10.6 (0.0-25.2)
Lander	0	-
Lincoln	3	66.3 (0.0-141.3)
Lyon	6	8.9 (1.8-16.0)
Mineral	2	47.0 (0.0-112.2)
Nye	12	33.2 (14.4-52.0)
Pershing	1	12.4 (0.0-36.7)
Storey	0	-
Washoe	70	14.9 (11.4-18.4)
White Pine	1	11.6 (0.0-34.2)
Statewide	387	12.8 (11.5-14.1)

*Data are preliminary and are subject to change.
(Sources: Office of Public Health Informatics and Epidemiology; Electronic Death Registry System)

Opiate-involved overdose deaths were significantly higher among white residents and significantly lower among Hispanic and Asian/Pacific Islander residents.

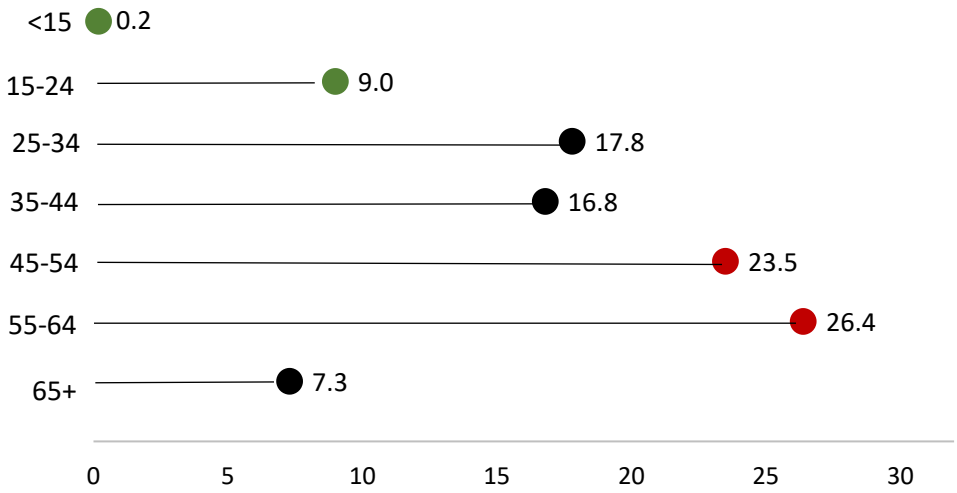
Figure 4. Opioid Overdose Death Rates, by Race/Ethnicity, 2016



(Sources: Office of Public Health Informatics and Epidemiology; Electronic Death Registry System)

Age groups affected greatest by opioid deaths were ages 45-54 and ages 55-64, with death rates significantly higher.

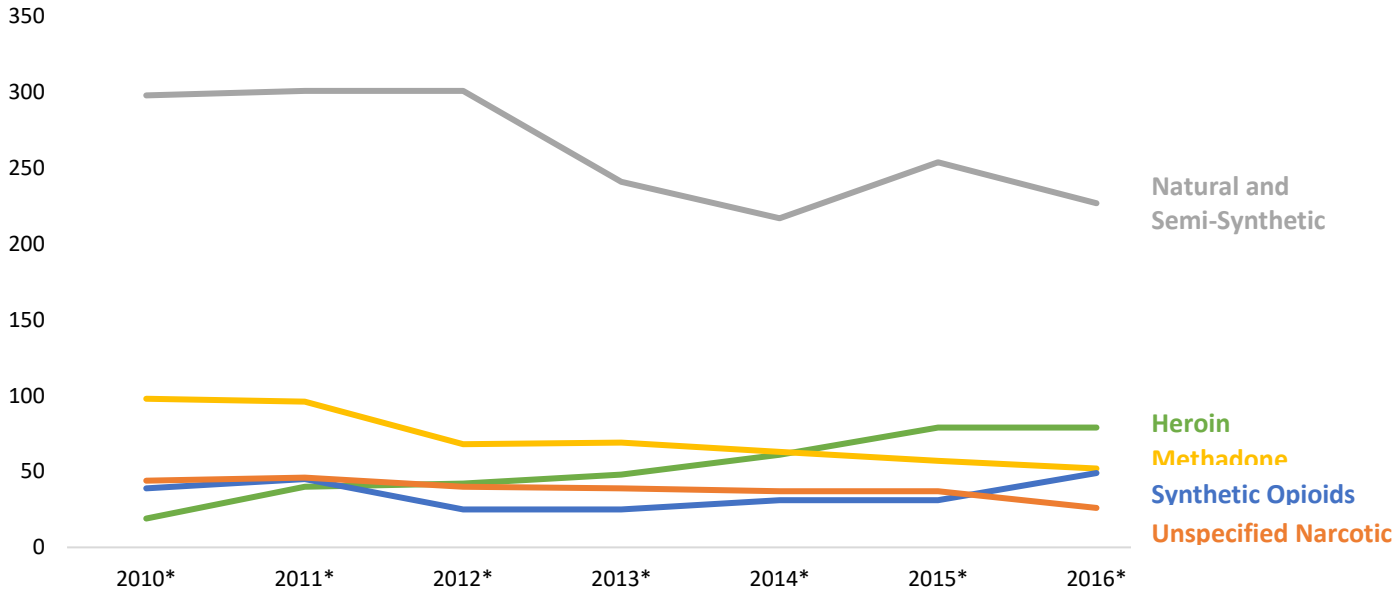
Figure 5. Opioid Overdose Death Rates, by Age, 2016



(Sources: Office of Public Health Informatics and Epidemiology; Electronic Death Registry System)

Opioid overdose deaths were significantly greater for natural and semi-synthetic (i.e. hydrocodone) opioids for all years displayed. Natural and semi-synthetic deaths are on a decreasing trend since 2012. From 2010-2015, heroin deaths increased, then remained stable from 2015-2016. From 2015-2016, synthetic opioid deaths (i.e. fentanyl) increased. Methadone overdose deaths decreased from 2010-2016.

Figure 6. Opioid Overdose Deaths by Drug Category, Nevada Residents, 2010-2016



(Source: Office of Public Health Informatics and Epidemiology)

*Data are preliminary and are subject to change.

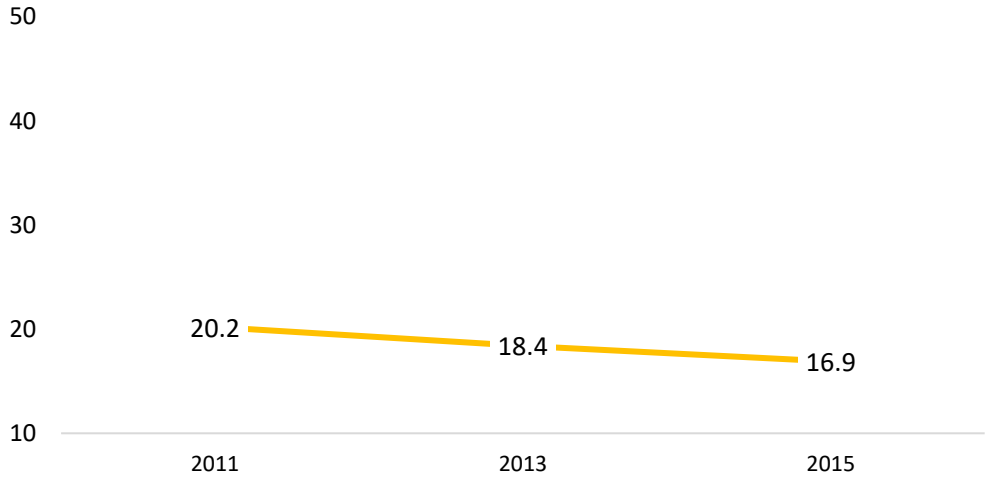
**A person can be included in more than one drug group, and therefore the counts above are not mutually exclusive.

Misuse and Related Harms

Adolescent Misuse

The proportion of high school students who self-reported ever using a prescription drug without a doctor's prescription decreased, though not significantly, from 20.2% to 16.9% from 2011-2015. Prescription drugs were defined as any prescription drugs including, but not limited to: Oxycontin, Percocet, Vicodin, Codeine, Adderall, Ritalin, or Xanax. Due to this broad definition, the question is more of a proxy for prescription opioid use rather than a direct measurement.

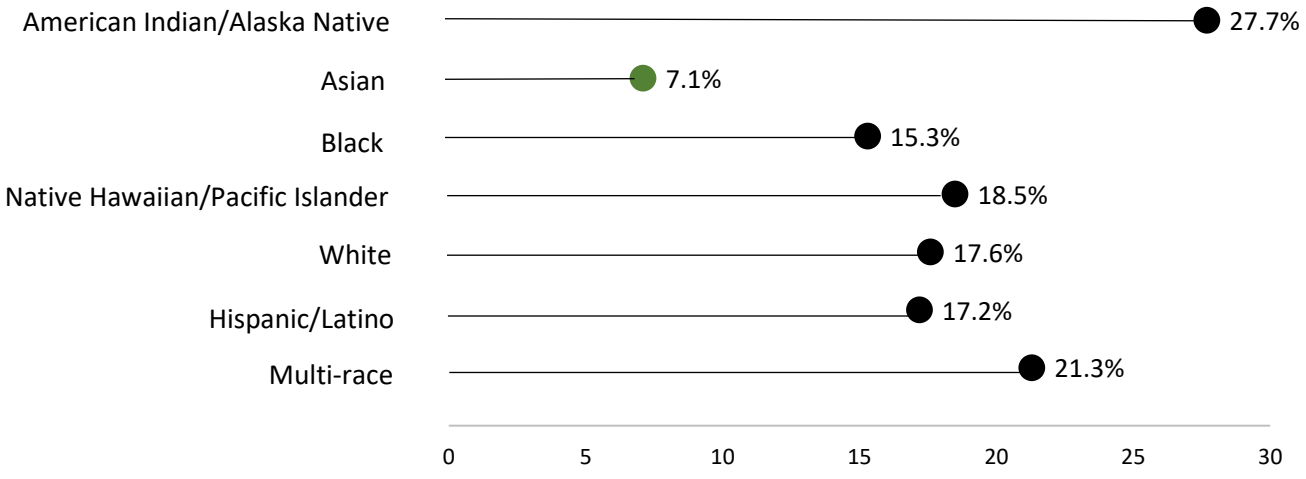
Figure 7. Lifetime Prescription Drug Use, 2011-2015



(Sources: Youth Risk Behavior Surveillance System; OPHIE; Lensch, et al., 2015; Hartley, 2012)

Weighted lifetime prescription drug use was significantly lower among Asian students (7.1%). The same disparity existed for past 30-day prescription drug use, with 4.0% of Asians reporting current use, compared to 9% of the state sample.

Figure 8. Lifetime Prescription Drug Use, by Race/Ethnicity, 2015



(Source: Lensch et al., 2015)

Lifetime and past month use of a prescription drug without a prescription in high school did not change significantly from 2013-2015. Lifetime use did not vary significantly from county to county. Past month prescription drug misuse was lower in Elko/White Pine/Eureka counties at 5.8% and Churchill/Humboldt/Pershing/Lander counties at 5.6%, compared to 9% overall (not pictured). The source of the high school data aggregates some counties together so it is not known if the county groupings increased or decreased the total percentage.

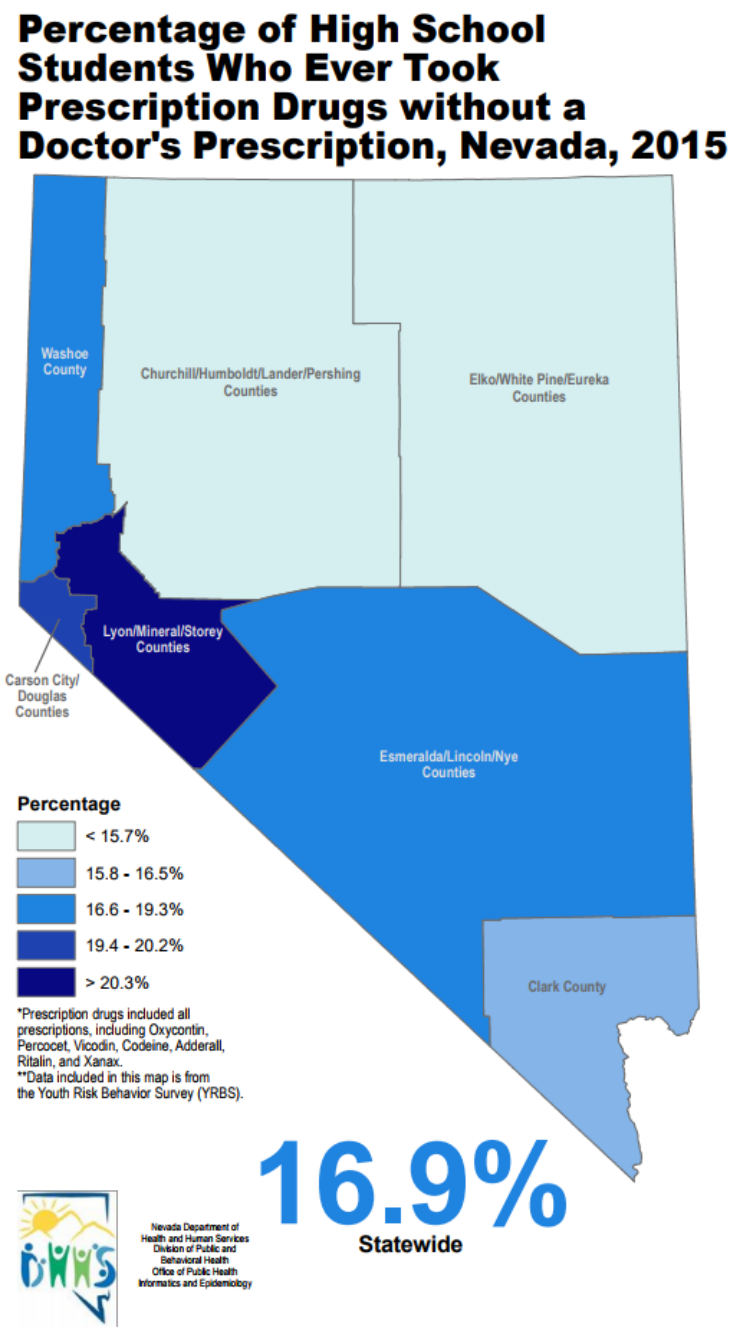
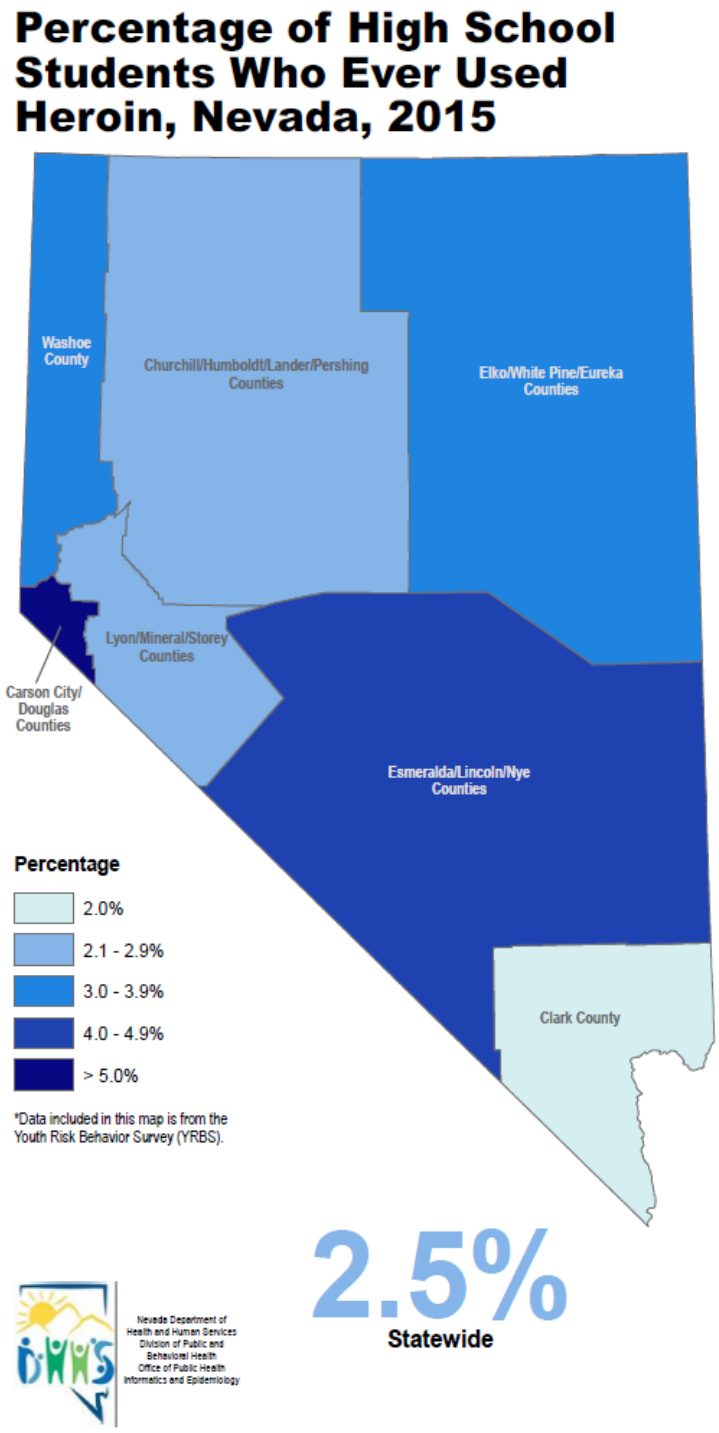


Table 4. Percentage of High School Students Who Ever Took Prescription Drugs without a Doctor's Prescription, 2015

County	Percentage
Carson City/Douglas	20.2% (9.1-31.3)
Churchill/Humboldt/ Lander/Pershing	15.7% (10.5-21.0)
Clark	16.5% (14.5-18.5)
Elko/White Pine/ Eureka	15.1% (9.2-21.0)
Lincoln/Nye	19.3% (14.5-24.2)
Lyon/Mineral/Storey	21.7% (15.7-27.7)
Washoe	18.3% (14.9-21.6)
Statewide	16.9% (15.3-18.6)

(Source: YRBS)



Self-reported lifetime heroin use in high school did not change significantly from 2013 to 2015. Lifetime heroin use did not differ significantly by county or race/ethnicity, as the number students indicating use was low. Again, the high school data contains aggregated counties which may affect rankings.

Table 5. Percentage of High School Students Who Ever Used Heroin, 2015

Counties	Percentage
Carson City/Douglas	9.0% (0.0-18.7)
Churchill/Humboldt/ Lander/Pershing	2.1% (0.2-4.0)
Clark	2.0% (1.3-2.6)
Elko/White Pine/ Eureka	3.3% (1.0-5.7)
Lincoln/Nye	4.6% (2.4-6.7)
Lyon/Mineral/Storey	2.7% (0.0-5.5)
Washoe	3.5% (1.9-5.0)
Statewide	2.5% (1.9-3.1)

(Source: YRBS)

Adult Misuse

According to the National Survey on Drug Use and Health (NSDUH), Nevada ranks fourth for the percentage of people aged 12 or older who used prescription pain relievers nonmedically in the past year from 2012-2014 (5.20%), down from second from 2010-2012 (5.92%) (Lipari et al., 2017).

The Behavior Risk Factor Surveillance System instead assesses past 30-day use of a painkiller to get high, where 0.7% of adults in Nevada indicated yes, in aggregated data from 2013-2016.

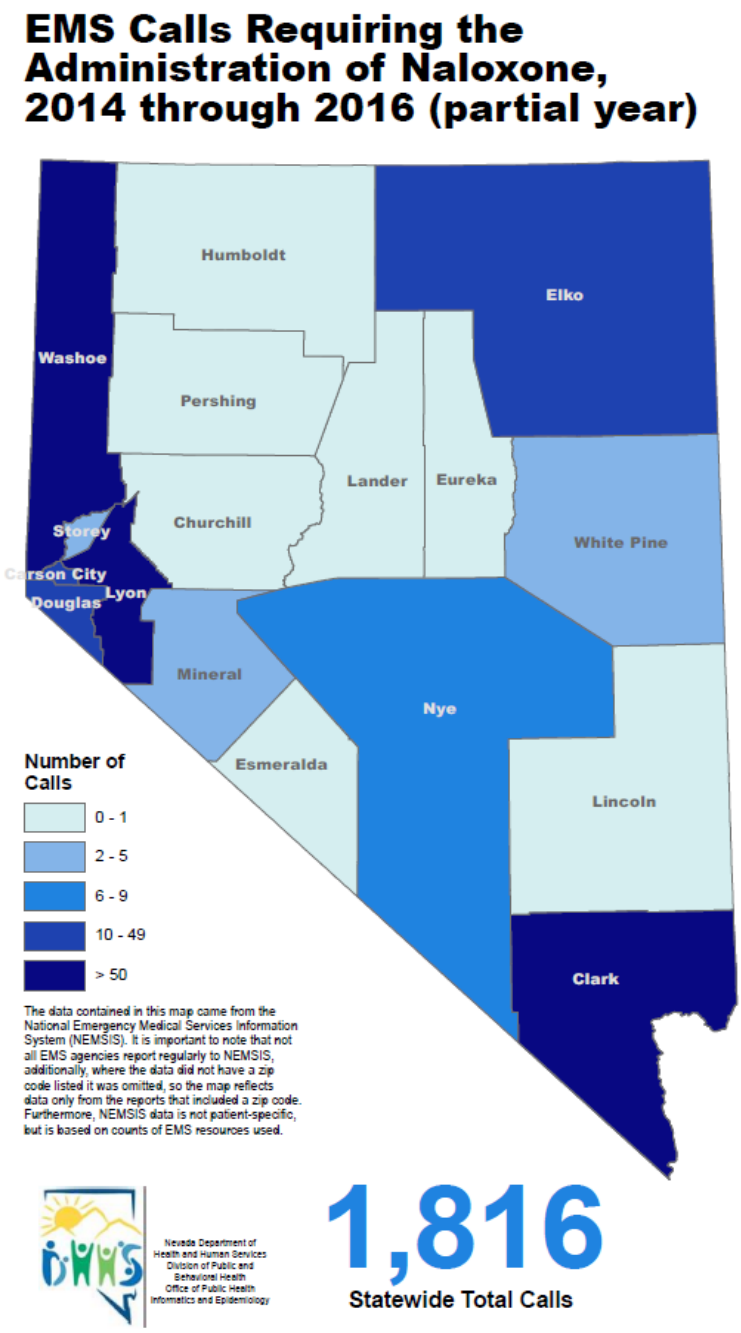
Table 6. Past Month Percentage Who Used a Painkiller to Get High, by County, 2013-2016

County	Percentage
Carson City	0.7%
Churchill	0.1%
Clark	0.6%
Douglas	1.2%
Elko	0.7%
Esmeralda	0.0%
Eureka	0.0%
Humboldt	0.0%
Lander	0.0%
Lincoln	0.0%
Lyon	1.5%
Mineral	1.2%
Nye	0.5%
Pershing	0.0%
Storey	0.3%
Washoe	1.0%
White Pine	0.0%
Statewide	0.7%

(Source: Behavioral Risk Factor Surveillance System)

Past year heroin use in Nevada among those aged 12 or older was the same as the national average of 0.33% in 2014-2015 (SAMHSA, 2017).

Medical Interventions



The rate of EMS calls requiring administration of naloxone is higher for Lyon County. Of the seven counties listed in the 0-1 calls category, five counties had zero EMS calls requiring naloxone administration: Esmeralda, Humboldt, Lander, Lincoln, and Pershing. Lincoln County EMS was part of the NROOR funding and had naloxone on the ambulances. It is unknown if naloxone is carried by EMS in the other counties with no administration.

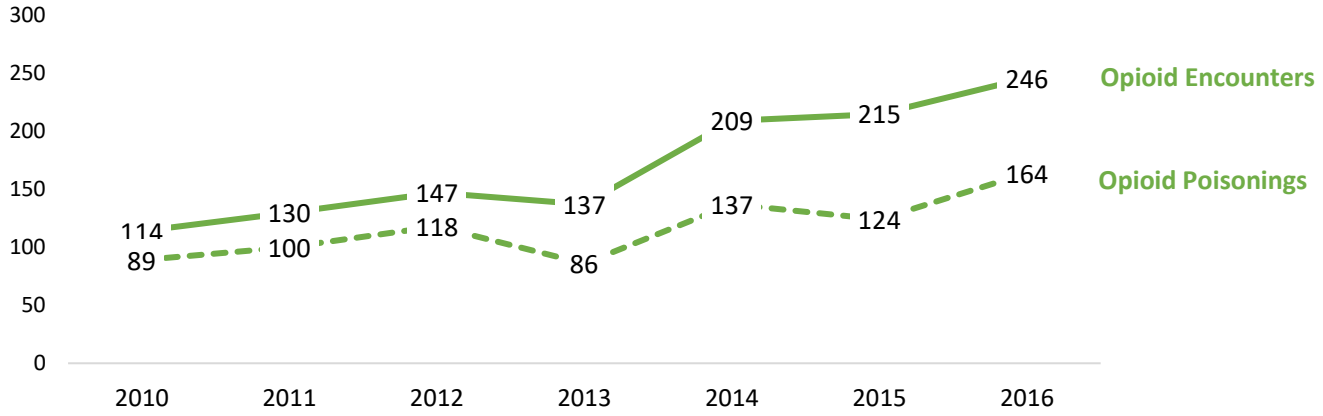
Table 7. Rate of EMS Calls Requiring Naloxone by County, 2014-2016

County	Number	Crude Rate
Carson City	49	30.1 (21.7 - 38.5)
Churchill	1	1.3 (0.0 - 3.9)
Clark	1,089	17.3 (16.3 - 18.4)
Douglas	14	9.6 (4.6 - 14.6)
Elko	47	29.6 (21.1 - 38.0)
Esmeralda	0	0.0
Eureka	1	17.3 (0.0 - 51.1)
Humboldt	0	0.0
Lander	0	0.0
Lincoln	0	0.0
Lyon	86	53.1 (41.8 - 64.3)
Mineral	3	21.7 (0.0 - 46.2)
Nye	6	4.4 (0.9 - 8.0)
Pershing	0	0.0
Storey	3	24.7 (0.0 - 52.7)
Washoe	513	38.7 (35.4 - 42.1)
White Pine	4	13.2 (0.3 - 26.1)

(Source: NEMSIS)

Naloxone administration in emergency departments increased from 2013-2016. Naloxone was only used for a small percentage of total opioid poisonings (15.2%) and opioid encounters (3.8%).

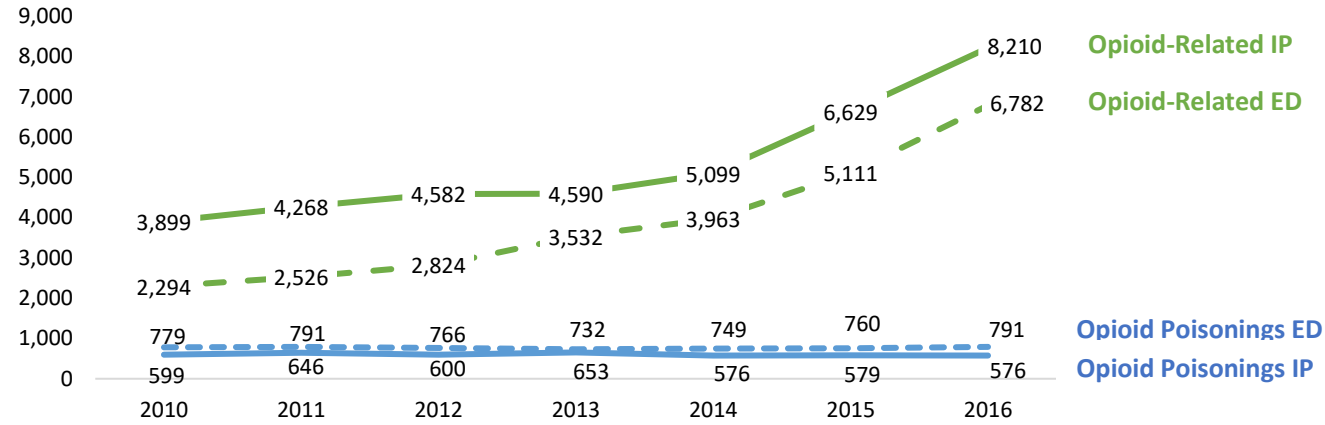
Figure 9. Emergency Department Naloxone Administrations, 2010-2016



(Source: OPHIE, Emergency Department Billing Data)
*Includes ICD-9 Codes of 965.0, 304.0, 304.7, 305.5, E850.0, E850.1, E850.2 and ICD-10 Codes of T40.0-T40.4, and T40.6, F11, and J23.10.
**Opioid poisonings are a subset of opioid encounters.

Both ED and IP admissions for opiates increased from 2010-2016. Opioid poisonings, a subset of opioid-related admissions, remained steady during those same years among ED and IP admissions. In 2014, the highest rate of opioid-related IP stays was among individuals aged 45-64 years, while opioid-related ED visits were highest among 25-44 year olds. ED visits were highest in this age group in all 30 states for which ED data were available. There was variation among highest age group for IP admissions, with rates highest among individuals 45-64 years in only nine states. Females had a higher rate of IP stays, while men had a higher rate of ED visits (Weiss et al., 2017).

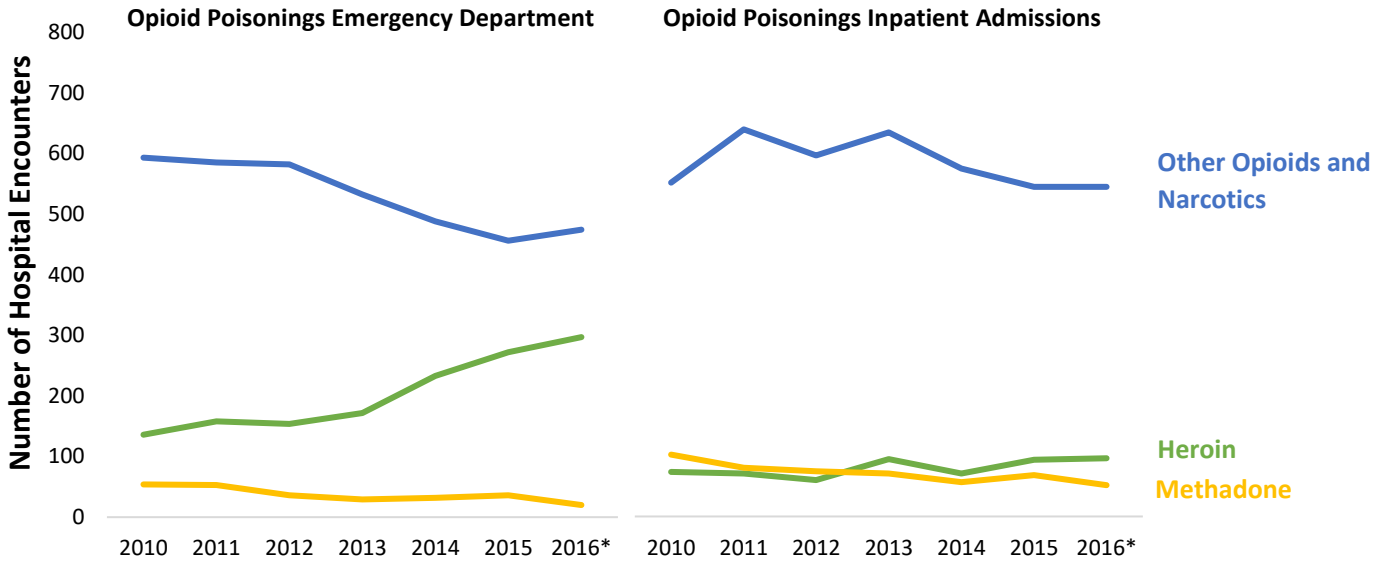
Figure 10. Opiate-Related Hospital Admissions, 2010-2016



(Source: Center for Health Information Analysis, Hospital Inpatient and Emergency Department Billing Data)
*A person can be included in more than one drug group, therefore the counts above are not mutually exclusive.
**In October 2015, ICD-10-CM codes were implemented. Previous to October 2015, ICD-9-CM codes were used for medical billing. Therefore, 2015 data consists of two distinct coding schemes, ICD-9-CM and ICD-10-CM respectively. Due to this change in coding schemes, hospital billing data from October 2015 forward may not be directly comparable to previous data.

While Figure 10 shows the number of opioid poisonings has remained stable, Figure 11 displays that the type of opioid drug causing opioid poisonings has changed. Opioid poisonings from heroin have increased in the ED and methadone and other opioid and narcotics have decreased in ED and IP admissions.

Figure 11. Opioid-Related Poisoning Hospital Admissions by Drug Category, 2010-2016



*A person can be included in more than one drug group, and therefore counts are not mutually exclusive. In 2016, the use of E-codes was eliminated and counts are now mutually exclusive.

Self-reported heroin use and opiate use while pregnant by county is listed in Table 8.

Table 8. Rate of Self-Reported Opiate Use While Pregnant, 2012-2016

County	Heroin	Opiates
Carson City/Douglas	2.0	0.7
Churchill/Humboldt/Lander/Pershing	0.3	0.8
Clark	0.7	1.7
Elko/Eureka/White Pine	0.3	2.4
Esmeralda/Lincoln/Nye	5.2	2.1
Lyon/Mineral/Storey	1.9	1.3
Washoe	1.0	1.1
Statewide	.8	1.6

*Rates are per 1,000 births

**Data are preliminary and subject to change.

State of Current Services and Funding

Availability of Medication-Assisted Treatment

There are 15 Opioid Treatment Programs (OTPs) in Nevada across Clark County, Washoe County, and Carson City (see Table 10). Only one OTP location, Life Change Center Sparks, is at capacity. To address this, they are planning to open another facility in Reno. The two Mission Treatment Center locations and the four Center for Behavioral Health locations said they would add more staff as client levels increased, stating that there was no limit to their capacity. One OTP does not provide maintenance therapy, as it is only using MAT to detox and then refer the client to another provider. The 14 rural counties in Nevada have no OTPs. Capacity to provide MAT services among the 12 clinics responding to inquiry is 4,693 clients. No information was available on the remaining three facilities.

Three OTPs, Adelson Clinic in Clark County and Life Change Center (one location in Washoe County and one in Carson City), receive funding from SAPTA through the Federal Block Grant. At those facilities, the majority of clientele seeking MAT are publicly funded. Requests for number served who are publicly funded or privately funded were not returned by 12 OTPs, but most clients should be privately funded at those facilities. See Table 9 for more information on county served, program capacity, and psychosocial interventions offered.

Table 9. Nevada Opioid Treatment Program Location, Capacity, and Services

Program	County	Program Capacity	Current Number Served	Number served - publicly funded		Number served - privately funded	Psychosocial interventions offered
Adelson Clinic	Clark	300	183	Medicaid 69	SAPTA 75	21	Counseling and refer/coordination of care for other services needed by clients
Center for Behavioral Health							
• Center for Behavioral Health – Cheyenne	Clark	200	200	--		--	Counseling (variety of groups, including gender specific), family counseling, case management, coordinate care when mental health services are needed, physician available everyday
• Center for Behavioral Health – Desert Inn	Clark	450	450	--		--	Counseling (variety of groups, including gender-specific), family counseling, case management, coordinate care when mental health services are needed, physician available everyday
• Center for Behavioral	Clark	400	400	--		--	Counseling (variety of groups, including gender-specific), family counseling,

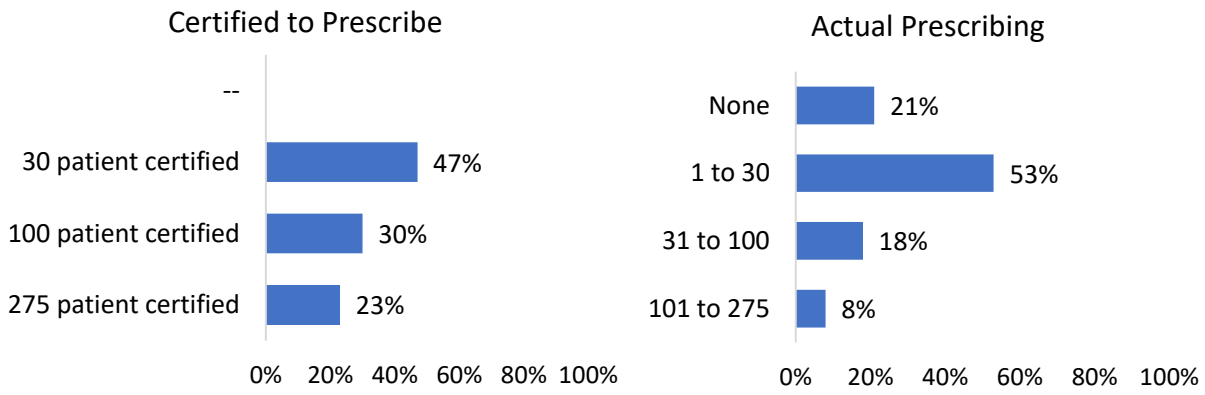
Program	County	Program Capacity	Current Number Served	Number served - publicly funded	Number served - privately funded	Psychosocial interventions offered
Health – McDaniel						case management, coordinate care when mental health services are needed, physician available everyday
• Center for Behavioral Health – Reno	Washoe	300	300	--	--	Counseling (variety of groups, including gender-specific), Family Counseling, case management, coordinate care when mental health services are needed, Physician available 2 days per week
Desert Treatment Clinic	Clark	--	--	--	--	--
Eastern Treatment Clinic	Clark	--	--	--	--	--
Mission Treatment Centers						
• Mission Treatment Centers Henderson	Clark	258	258	--	--	Counseling, coordinate care with other agencies for the client's needs (medical, mental health)
• Mission Treatment Centers Las Vegas	Clark	260	260	--	--	Counseling, coordinate care with other agencies for the client's needs (Medical, Mental Health)
Nevada Treatment Center (Nevada Integrated Behavioral Services Inc.)	Clark	300	125	--	--	Counseling (L1, 2.1 and 2.5), case management, COD services, coordination of care for client's needs.
New Beginnings Counseling Center Eastern	Clark	800	490	--	--	Counseling, domestic violence, DUI class and the victim impact panel
New Beginnings Counseling	Clark	500	180	--	--	Counseling, domestic violence, DUI class and the victim impact panel

Program	County	Program Capacity	Current Number Served	Number served - publicly funded		Number served - privately funded	Psychosocial interventions offered
Center Lake Mead							
Life Change Center				Medicaid 435	SAPTA 107	241	
• Life Change Center – Carson City	Carson	275	275				Counseling; case management by dedicated CM staff; family programming: for women: parenting and prevention program, co-occurring capable program so can screen and then assist with referral and coordination of care; medication management; assessment for initial clients for proper placement; gardening program; social recreation program
• Life Change Center – Sparks	Washoe	450	450				Counseling; case management by dedicated CM staff; family programming: for women: parenting and prevention program, co-occurring capable program so can screen and then assist with referral and coordination of care; medication management; assessment for initial clients for proper placement; gardening program; social recreation program
Seven Hills Hospital, Inc.	Clark	--	--	--		--	None

In August 2017, all 192 Data 2000 waivered providers were emailed a brief survey inquiring about their buprenorphine prescribing limit, current caseload of MAT patients, reasons for not prescribing at capacity, resources that could increase their MAT prescribing, counties prescribing in, use of opioid and naloxone co-prescribing, psychosocial interventions offered and interventions provided through contract arrangements. Ten email addresses were "undeliverable," reducing the sample to 182. The survey received 84 responses, with eight indicating they did not want to participate and five not completing the survey, leaving 71 responses for analysis. Survey results presented below should be interpreted with caution, as only 39% of Data 2000 waivered providers completed the survey.

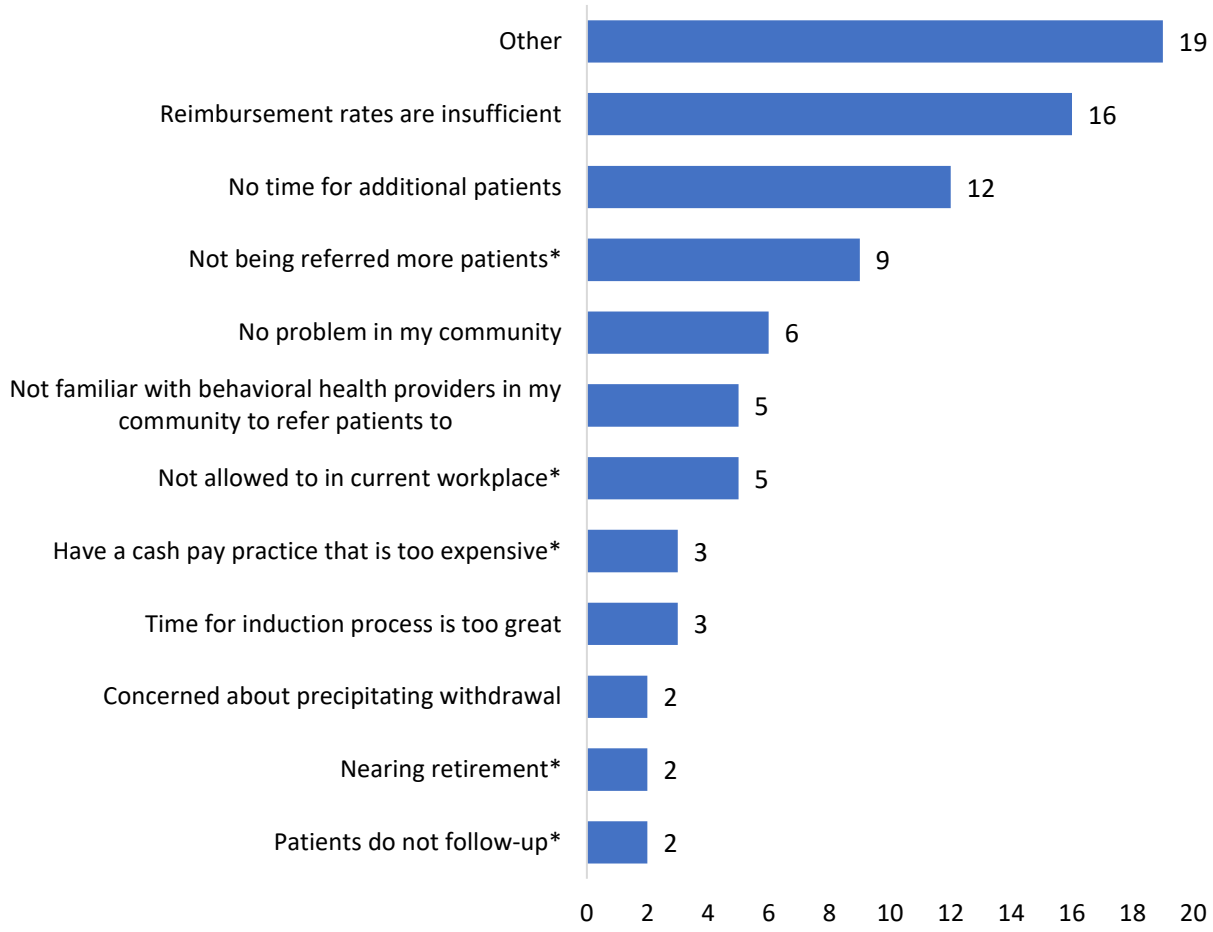
OBOTs prescribe in 10 counties: Carson City (5), Churchill (2), Clark (147), Elko (3), Humboldt (1), Lincoln (1), Lyon (1), Nye (1), Pershing (2), and Washoe (30). Of the OBOTs who responded to our electronic survey, none were prescribing at their capacity, although one had just increased their limit so they were prescribing to their prior capacity. Three-quarters (75%) of respondents work in private practice. Nearly all (97%) of respondents said their practice/agency was accepting new clients. The number of patients the providers were certified to prescribe to ranged, with 47% *30 patient certified*, 30% *100 patient certified*, and 23% *275 patient certified*. While less than half (47%) of providers were certified to prescribe to only 30 patients, 74% of respondents were prescribing in this range. Almost one-third (30%) were allowed to prescribe buprenorphine to up to 100 patients, but only 18% of respondents actually were. Finally, while nearly one-quarter (23%) had increased their prescribing limit to 275 patients, 8% were utilizing this ability (see Figure 12).

Figure 12. Comparison of Provider Capacity and Actual Prescribing



Respondents were asked to select all of the reasons that they were not prescribing at their Buprenorphine capacity and given the opportunity to write in other reasons that were not listed. As shown in Figure 13, the most often cited reasons for not prescribing at capacity were *no time for reimbursement rates insufficient*, *additional patients*, and *not being referred more patients*.

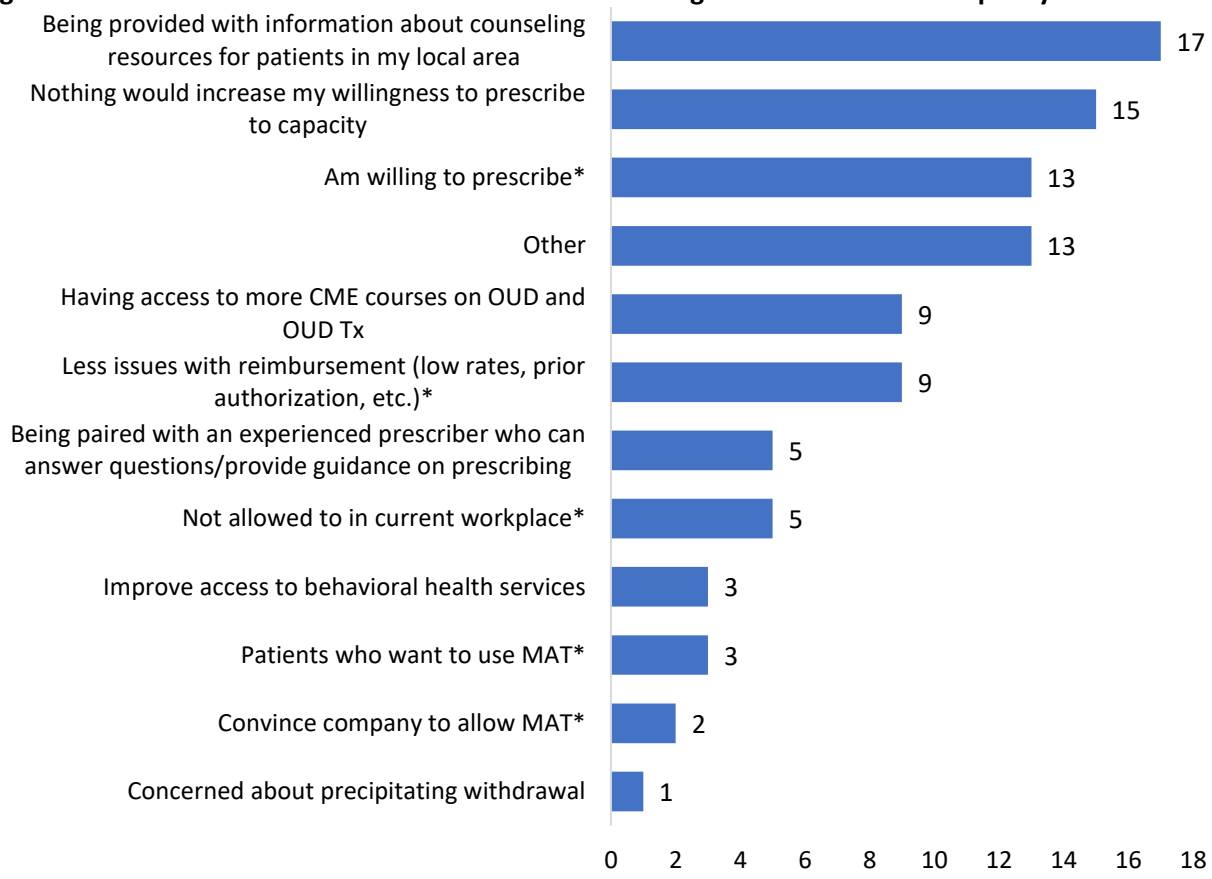
Figure 13. Reasons for Not Prescribing at Capacity



*represents aggregated responses written into Other
**Question was a select all that apply so the number of answers is more than the number of respondents

As a follow-up, participants were then asked what resources would increase their willingness to prescribe to capacity. The most common response was that the prescriber would like "*being provided with information about counseling resources for patients in my local area,"* followed by that "*nothing would increase my willingness to prescribe to capacity."*

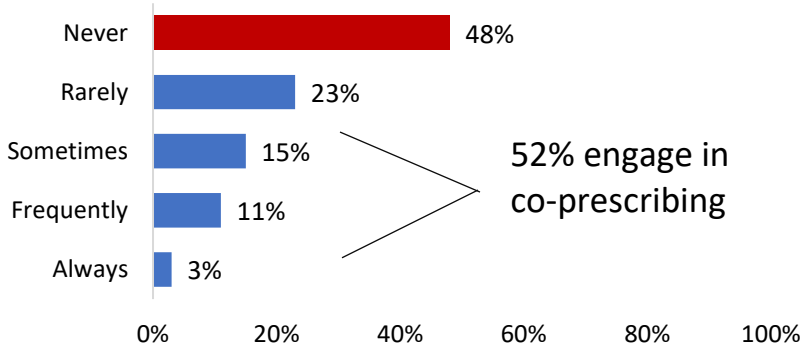
Figure 14. Resources that Would Increase Providers' Willingness to Prescribe at Capacity



*represents aggregated responses written into "Other"
**Question was a select all that apply so the number of answers is more than the number of respondents.

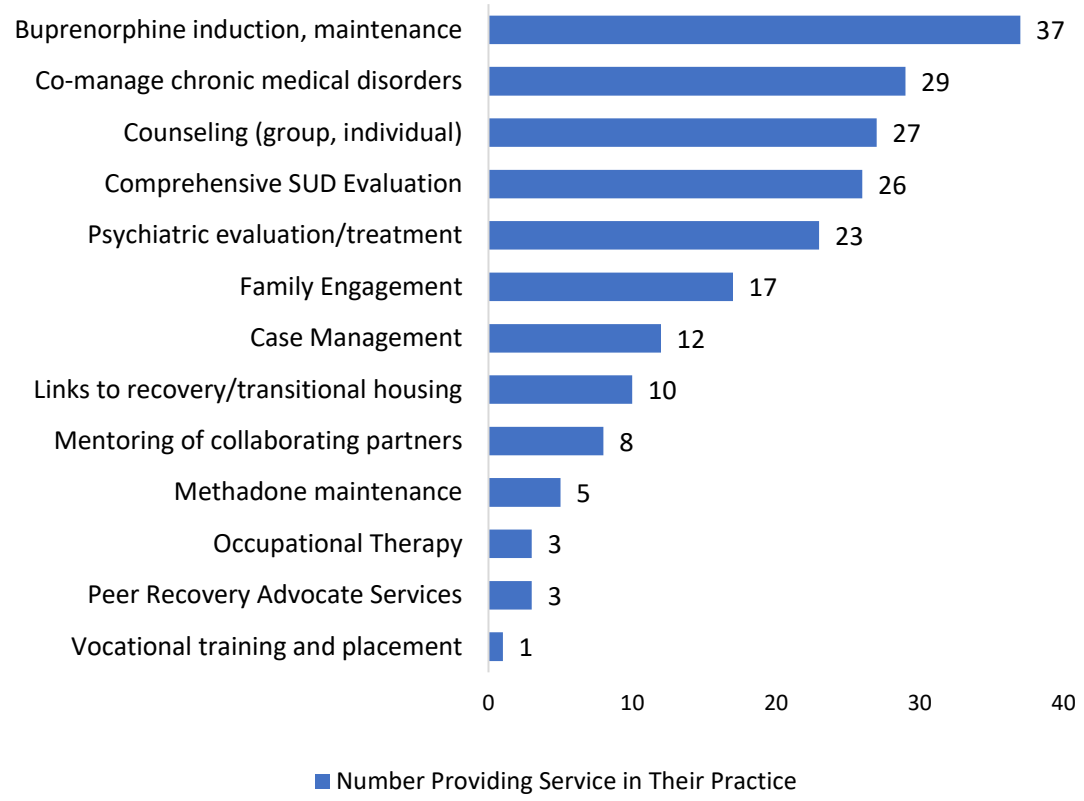
Over half (52%) of survey respondents indicated that they co-prescribed naloxone with opioid painkillers for high-risk patients, with 11% of those citing doing so "*frequently"* and 3% "*always*."

Figure 15. Frequency of Opioid Painkiller and Naloxone Co-prescribing



The majority of survey respondents (69%) were employed in a practice that offered psychosocial services or interventions and 48% provided psychosocial interventions through contract arrangements with qualified behavioral health providers. The most common service offered was buprenorphine induction and maintenance. Counseling and Substance Use Disorder Evaluation were also common responses.

Figure 16. Types of Psychosocial Services/Interventions Offered by Provider Practices



Socio-Political Environment

Policy/legislation passed in Nevada related to the opioid overdose crisis supportive of MAT is summarized below.

The Good Samaritan Drug Overdose Act of 2015 (SB 459) provides for immunity from prosecution for personal use and possession of controlled substances from individuals seeking medical attention for themselves or others during a drug overdose. Immunity does not extend to large quantities for sale or trafficking.

SB 459 requires that prescribing physicians obtain a patient utilization report on the Prescription Monitoring Program before the initiation of a schedule II, III, or IV prescription drug for a new patient, or for a course of treatment lasting longer than seven days that is part of a new course of treatment for an existing patient. SB 459 also requires the pharmacists to update the system within the next business day of filling a prescription. Participation in the PMP has increased from 16% to 90% since the legislation passed.

With the passage of SB 459, a physician is allowed to prescribe an opioid antagonist (i.e. naloxone) directly or by standing order to a person who is at risk of overdose or to a family member, friend, or other person in a position to assist a person who is at risk of experiencing an overdose. Additionally, SB 459 allows a pharmacist to dispense an opioid antagonist without a prescription. Finally, an unlicensed person may store and/or dispense an opioid antagonist under a standing order from a properly authorized prescriber, as long as the medication is dispensed without charge or compensation.

In 2016, Nevada Gov. Sandoval established a Drug Abuse Prevention Task Force led by First Lady Kathleen Sandoval. The governor convened and chaired a statewide drug summit in the summer of 2016. The summit assembled over 500 stakeholders, including legislators, healthcare professionals, law enforcement, judges, and individuals in recovery from a substance use disorder. Based on their recommendations, Gov. Sandoval announced in his 2017 State of the State Address that he was introducing the Controlled Substance Abuse Prevention Act, which will provide more training and reporting, and heightened protocols for healthcare professionals with prescribing controlled substances. Additionally, the Nevada Attorney General chairs a Substance Abuse Working Group consisting of nine members. The Working Group submitted recommendations for combating the opioid crisis to the Nevada Legislature. The Office of the Attorney General proposed SB 59, utilizing the recommendations of the Working Group. SB 59 requires reporting of controlled-substance violations, prescription drug-related overdoses or deaths, and stolen prescription drugs to the PMP. The bill went into effect on July 1, 2017.

The Controlled Substances Abuse Prevention Act (AB 474), which went into effect on Jan. 1, 2018, requires doctors and hospitals to report any drug overdoses to the state. Additionally, licensing boards can access PMP data to investigate inappropriate prescribing, dispensing, or use of a controlled substance. Prescribers will now need to perform a risk assessment before prescribing a controlled substance. For prescriptions over 30 days in length, a prescription medical agreement with the patient must be created. The prescriber must also complete a risk of abuse assessment and obtain a patient utilization report every 90 days for the duration of the prescription. Numerous trainings have been held and materials distributed to educate healthcare providers on AB 474.

Any physician or physician's assistant who is registered to prescribe controlled substances must complete at least two hours of training specifically addressing the prescribing of opioids or addiction every licensing period.

There is no dedicated state funding for MAT. All funding is allocated from the Block Grant. Dedicated state funding does not exist for naloxone either. The Commission on Behavioral Health has approved new criteria so programs will no longer be able to deny clients residential treatment who are stabilized on MAT. The new criteria went into effect April 1, 2018.

All opioid dependence and overdose reversal medications are covered by three managed care organizations (MCOs)—Amerigroup, Health Plan of Nevada, and Silver Summit Health Plan—but prior authorization and quantity limits differ. Table 10 displays prior authorization and quantity limits required by each plan.

Table 10. Health Care Plan Prior Authorization and Quantity Limits by Medication

Medication	Amerigroup		Health Plan of Nevada		Silver Summit Health Plan		Fee for Service	
	PA	Quantity Limits	PA	Quantity Limits	PA	Quantity Limits	PA	Quantity Limits
Overdose Medications								
Narcan (naloxone)		•				•		
Narcan Nasal Spray (naloxone)	•	•	•	•				
Evzio (naloxone)			•		•			
Opioid Dependence Medications								
Vivitrol (naltrexone)	•		•		•		•	•
ReVia (naltrexone)					•			
Suboxone (buprenorphine/ naloxone [bup/nal])	•	•	•	•	•	•	•	•
Zubsolv (bup/nal)	•	•	•	•	•	•	•	•
Bunavil (bup/nal)	•	•	•	•	•	•	•	•
Subutex (buprenorphine)		•	•	•	•	•	•	•
Detoxification/Withdrawal Medications								
Dolphine (methadone)	•	•			•	•		
Methadose (methadone)	•	•			•	•		

(Announcement 0921, 2017)

**Prior Authorization (PA)

Naloxone Prevention Initiatives

When this needs assessment was first conducted in July 2017, naloxone distribution was limited to pharmacies and a few hospitals. Naloxone is available without a prescription through standing orders at Walgreens and CVS Pharmacies and Smith's Food and Drug Stores. Naloxone is distributed at five (5) Nevada Rural Opioid Overdose Reversal Program (NROOR) funded hospitals in Lincoln, Lyon, Mineral, Nye, and White Pine counties to patients discharging from the hospital following an overdose.

Overdose education and naloxone distribution (OEND) has expanded in 2018 through Opioid STR funding and activities. Overdose education includes training on how to recognize an overdose, the Good Samaritan law, and how to administer naloxone. Community-based organizations (CBO) can apply to serve as naloxone distribution sites. Eligible CBO types include:

- Needle exchange programs,
- SAPTA certified or Medicaid eligible providers providing treatment services,
- Federally Qualified Health Centers (FQHC),
- Jails,
- Peer recovery communities,
- Health districts,

- Other STR funded treatment and recovery support entities.

**Exemptions to this criteria may be applied in rural and frontier high need areas or in cases of Public Health Emergency.*

To extend naloxone availability, upon request from partnering community coalitions, the STR grant will hold educational events to offer OEND to their constituents. A statewide tour of community coalitions began in June 2018.

Beginning in April 2017, Trac-B Exchange in Las Vegas opened the state's first permanent needle exchange, which also now delivers OEND free of charge. In Northern Nevada, Change Point Harm Reduction Center, provides OEND, along with syringe services and rapid HIV and hepatitis C testing. The three Integrated Opioid Treatment and Recovery Centers (IOTRC) are offering OEND to clients that are at risk of overdose, transitional living facilities, homeless shelters, community-based organizations, and weekly motels. Southern Nevada Health District is a SAMHSA First Responders – Comprehensive Addiction and Recovery Act grantee, delivering OEND services throughout Clark County.

There is a gap in the availability of naloxone among individuals who are legally prescribed painkillers by their doctor, with the co-prescribing of naloxone and opioids currently being underutilized by healthcare providers. Since NROOR only distributes at the five hospitals, patients in the other counties are left without access to naloxone when they are at greater risk of an overdose leaving the hospital. IOTRC Mobile Outreach Team services will be expanding into emergency rooms, reducing this gap in several hospitals.

NROOR has trained 117 EMTs on overdose education and naloxone administration. Although not specifically education on naloxone, 46 healthcare providers, 37 mental health professionals, drug court professionals, and attendees of a community college library committee event received training on overdose education. Presentations on integrating naloxone and overdose prevention into clinical practice were given at the annual meeting of the Nevada Academy of Family Physicians and at the annual Orvis Nursing School healthcare symposium. The Nevada Rural Preparedness Summit provided a presentation on expanding naloxone access. The Carson City Law Enforcement Summit and the Las Vegas Opioid Crisis Summit included naloxone training. One coalition, covering the three rural counties of Humboldt, Pershing, and Lander counties, is training first responders on naloxone (Stein-Seroussi, Grabarek, & Hanley, 2016).

Prevention Efforts

A description of Nevada's current prevention efforts, which are primarily completed SAMHSA Strategic Prevention Framework – Partnership for Success-funded community coalitions, are summarized below.

Social marketing/media campaigns are a strategy being implemented by 11 community coalitions, including nearly 10,000 paid ads and 14,000 public service announcements (Stein-Seroussi et al., 2016). Coalitions had a media presence with the release of 'Women of Childbearing Years,' an opioid prevention TV ad; and students from Pershing County High School produced prescription drug abuse ads. An associated website was also created (www.healthiernv.org) to provide information to prescribers, families and policymakers.

Eight (8) community coalitions coordinate semi-annual Take Back events and utilize drop boxes in law enforcement facilities in between Take Back events (Stein-Seroussi et al., 2016). Funded by the Federal

Office of Rural Health Policy, NROOR is providing naloxone to EMTs and paramedics and training them on its use in seven counties: Esmeralda, Eureka, Lincoln, Lyon, Mineral, Nye and White Pine.

Eleven coalitions have reported coordinating continuing education opportunities for physicians (Stein-Seroussi, Grabarek, & Hanley, 2016). Additionally, presentations to educate parents, youth, seniors, real estate agents, and veterans are conducted statewide to help them understand issues.

Over the past year, four new websites have been created. Three Nevada websites target educating the public and providers on the opioids. Prescribe365, run by the State of Nevada Division of Public and Behavioral Health is a hub of information for patients and providers. Healthcare provider information includes educational materials surrounding AB 474 and naloxone co-prescribing. Consumer materials for patients, friends and family contain information on how to use naloxone and links to treatment locators. Know your Pain Meds is operated by the Nevada State Board of Examiners, Nevada State Board of Pharmacy, and Nevada State Board of Nursing. The website contains information on the PMP, naloxone, alternatives to opioids for managing pain, and filing a concern about a medical provider. The Nevada STR website has information on funding opportunities, training opportunities, naloxone education materials, and STR publications. The fourth website is designed to make local data available to the public. The Nevada Opioid Overdose Surveillance Dashboard contains death rates, opioid-related emergency department visits and inpatient admissions, and opioid prescriptions at the county- and zip-code level.

Recovery Support Initiatives

At this time, Nevada has one peer-run recovery community organization, Foundations for Recovery, which is in Las Vegas. Foundations for Recovery offers a peer-recovery community center; peer recovery coaching; mutual aid support groups; life skills classes; high school equivalency (HSE) tutoring and testing; parenting classes; mental health first aid; suicide prevention trainings; houses the Southern Nevada NAMI affiliate and hosts the annual Rally for Recovery. All services are available to the public, including women with children, and pregnant women. Foundations for Recovery staff was trained in Medication Assisted Recovery Services (MARS), which is a peer-initiated and peer-based recovery support project sponsored by the National Alliance of Medication-Assisted (NAMA) Recovery.

The state of Nevada, through the Nevada Behavioral Health Association, offers a voluntary certification process for peer-support specialists. In-person and online training opportunities are available for individuals seeking peer-support specialist training.

In 2015, Nevada was one of 24 states to be awarded a Certified Community Behavioral Health Clinic (CCBHC) demonstration grant through SAMSHA, under the Excellence in Mental Health Act. In 2016, the state became one of eight selected to carry out the formal implementation of CCBHCs. Phase 1 of the project offered states one-year planning grants to develop their CCBHC program and Phase 2 enabled the selected states to move forward with the development of CCHBCs. Nevada has two CCBHCs located throughout the state (two in rural areas) that provide a comprehensive range of mental health and substance use disorder services, particularly to vulnerable individuals with complex needs. Peer support and family support services are included in the array of services CCBHCs are required to offer and provide.

No efforts are targeting clients related to re-integration following incarceration at this time.

Other Opioid Funding Sources

All other funding to address the opioid crisis is described in Table 11.

Table 11. Nevada Funding to Address the Opioid Crisis

Funding Stream	*Strategies/Activities*	*Funding Period*
CDC Prevention for States (PFS)	• Expand and improve proactive reporting • Conduct public health surveillance with PMP data and disseminate quarterly reports • Identify and provide technical assistance to high-burden communities and counties to address problematic prescribing • Create an opioid data dashboard • Link deaths, hospitalizations, and prescriptions of individuals • Create mapping of funded activities to find gaps • Administer CDC's statewide media campaign • Link health data sets and law enforcement data sets	8/16-7/19
CDC Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality (ESOOS)	• Increase timeliness of aggregate nonfatal opioid overdose reporting • Increase the timeliness of fatal opioid overdose and associated risk factor reporting • Disseminate surveillance findings to key stakeholders working to prevent or respond to opioid overdoses	9/17-8/19
SAMHSA Strategic Framework Partnership for Success (PFS)	• Reduce the nonmedical use of prescription drugs among persons 12 and older and the consequences that result from such use, with a focus on persons ages 12-25 • Implement a comprehensive prevention strategy through community education, social marketing/media, physician training, and drop boxes/Take Back events through 13 funded coalitions	9/13-9/18
SAPG Block Grant: Funding Opportunity 003	• Target efforts to encourage the use of Prescription Drug Monitoring System by prescribers • Provide education on the use of naloxone and education on the Good Samaritan Law	4/17-9/19
Nevada Rural Opioid Overdose Reversal Program (NROOR)	• Provide naloxone administration training to EMS personnel • Provide initial stock of naloxone to EMS services that did not have it in their formulary • Provide patient education, substance abuse treatment referrals, and intranasal naloxone to opioid overdose patients upon discharge	9/15-8/17
FQHC Incubator Project	• Implement system design models that will most rapidly address the gaps in their systems of care • Deliver evidence-based treatment interventions including medication and psychosocial interventions • Report progress toward increasing availability of treatment for OUD and reducing opioid-related overdose deaths based upon measures developed in collaboration with the Department of Health and Human Services • Improve retention in care, using a chronic care model	Upon Receipt – 4/18
Harold Rogers Prescription Drug Monitoring Program Grant (Reno Police Department)	• Analyze PDMP data in order to identify high-risk populations, geographic hotspots, and the relationship between heroin arrests and opioid prescriptions	10/15-9/18

Attorney General Volkswagen Settlement Money	• Design and implement a program that promotes awareness and understanding of the dangers and consequences of prescription drug misuse • Connect those at risk of developing prescription drug dependency or abuse to preventive services • Provide education on the dangers of prescription misuse, neonatal exposure, youth accidental overdose • Provide resources for chronic pain management and preventive service programs to avert prescription drug misuse and dependency • Provide the locations of where unused prescription drugs can be taken for disposal and destruction • Promote awareness of proper storage of prescription drugs • Distribute naloxone to law enforcement	10/17-6/19
First Responders – Comprehensive Addiction and Recovery Act Cooperative Agreement (Southern Nevada Health District)	• Train individuals on using naloxone in a suspected overdose • Establish referral protocols • Join advisory council • Educate on Good Samaritan Law	10/17-10/21

Gaps in Services and Policies

Only three of Nevada's 17 counties are considered urban (Clark, Washoe, and Carson City), accounting for 91% of the state's population. The remaining counties are considered rural or frontier (meaning less than 1 person per 7 square miles). The average distance between acute care hospitals in rural Nevada and the next level of care or tertiary care hospital is 114.7 miles and the average distance to the nearest incorporated town is 46.5 miles (Griswold et al., 2017).

Nevada's rurality presents issues with access to care in all types of medical and behavioral health. MAT services are limited in rural areas, with OTPs only existing in the three urban counties. Access to OBOTs is better, with access in 10 counties: Washoe, Clark, Carson, Churchill, Elko, Humboldt, Lyon, Lincoln, Pershing, and Nye. There is still a gap in MAT when considering Mineral and Storey counties lack access to an OBOT and are counties with some of the highest percentages of individuals in treatment for opiates.

With naloxone distribution following hospitalization for an overdose only available at five rural hospitals in Mineral, Nye, Lyon, and Lincoln counties, patients in the remaining counties are still at risk. Some towns do not have any of the three pharmacies with standing orders for naloxone.

Recovery supports are limited in many regions to 12-step meetings and in some frontier communities such meetings are rare or non-existent.

With coordinated care management, not currently reimbursable by Medicaid, the connections between varying levels of care and necessary supports is lacking.

Resources

Centers for Disease Control and Prevention (CDC). (2017a, July 31). U.S. State Prescribing Rates, 2016. Retrieved from https://www.cdc.gov/drugoverdose/maps/rxstate2016.html

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Appendix A

Definitions

Office-based Opioid Treatment (OBOT) *ASAM*
Physicians and soon Physician Assistants and Nurse Practitioners in private practices or a number of types of public or private sector clinics can be authorized through a waiver to prescribe the partial opioid agonist buprenorphine or buprenorphine/naloxone (though OTPs can administer or dispense buprenorphine products as well through the waiver). There is no regulation per se of the clinic sites where buprenorphine-prescribers practice. It is the practice of the individual prescriber, which is regulated by FDA addressing office-based treatment.

Opioid Treatment Program (OTP) *ASAM*
Opioid treatment programs using methadone and/or buprenorphine are presented in The ASAM Criteria as a Level 1 outpatient service because opioid agonist medications are most commonly used for opioid use disorders and an outpatient setting is the context in which it is most commonly offered.

Previous terms for OTP are methadone maintenance treatment (MMT) or opioid maintenance therapy (OMT) as was used in the ASAM PPC-2R.

Opioid Treatment Services (OTS) *ASAM*
An umbrella term that encompasses a variety of pharmacological and non-pharmacological treatment modalities. This term broadens understanding of opioid treatments to include all medications used to treat opioid use disorders and the psychosocial services that are offered concurrently with these pharmacotherapies. Pharmacological agents include opioid agonist medications such as methadone and buprenorphine, and opioid antagonist medications such as naltrexone.

Medication Assisted Treatment (MAT) *SAMHSA*
The use of medications with counseling and behavioral therapies to treat substance use disorders and prevent opioid overdose.

Agonist
An opioid/drug that acts like another substance and activates certain receptors in the brain. It is the opposite of an antagonist medication. An example of an agonist medication is methadone.

Partial Opioid Agonist
An opioid that produces less effect than a full agonist when it binds to opioid receptors in the brain. An example of a partial agonist is buprenorphine (Subutex) and buprenorphine/naloxone (Suboxone).

Antagonist
A non-opioid that acts against and blocks an action. It binds to opioid receptors in the brain preventing the usual feelings of the opioid. It is the opposite of an agonist medication. An example of an antagonist is naltrexone and naloxone.

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